The Commonwealth of Massachusetts
Department of Public Health
Office of Patient Protection
1-800-436-7757
250 Washington Street, 2nd Floor
Boston, MA 02108

Physician Certification for Request for External Review of Treatment Deemed to be Experimental or Investigational by the Health Plan

I hereby certify that I am the treating physician for _____ (patient's name) and that I have requested the authorization for a drug, device, procedure or therapy that was denied coverage due to the health plan's determination that the proposed therapy is experimental and/or investigational.

Name of patient: _____

Patient's Phone Number _____

Patient's Health Plan Member ID Number: _____

Name of Physician completing this form: _____

Address: _____

_____

_____

Contact Person: _____

Phone Number: ( )_____

Fax Number: ( )_____

Please provide a description of the experimental or investigational drug, device, procedure, or other therapy recommended for the patient.

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In my medical opinion as the patient's treating physician, I hereby certify to the following:

1. The patient has a condition that qualifies under one or both of the following (please check all that apply):

   - ❑ Standard therapies have not been effective in improving the patient's condition.

   - ❑ Standard therapies would not be medically appropriate for the patient.

2. The treatment I have recommended and which has been denied is likely to be more beneficial to the patient than any available standard therapies, based on current clinical literature and medical evidence.

3. The proposed treatment has proven to be safe and effective for the diagnosis and patient in question, based on patient medical record documentation and scientific data.

   - ❑ The proposed treatment or technology has final approval from the appropriate governmental regulatory agency.

Please state the specific evidence relied upon in this determination. Please provide a description below or attach to this request form. Please add any other information that will demonstrate that the proposed treatment is reasonably expected to improve the patient's net health outcome.

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I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

Physician's Office Stamp:

_____
Print Physician's Name

_____
Specialty

_____ _____
Signature Date

Fax this completed certificate to 1-617-624-5046
Please call the Office of Patient Protection at 1-800-436-7757 if you have questions.